Prioritizing Correspondence

BY JENNIFER KROKEN, MBA

"Working correspondence" is a critical function in the billing office, and one of the differentiating factors between a top performing organization and an underachiever with lagging accounts receivable (A/R). But what does it mean, exactly?

Correspondence can be loosely defined as anything received from an insurance company or patient that is not a payment. In radiology "best practices" correspondence is a priority for the A/R follow-up team and often worked as the first task of the day, before reports or tickler worklists are addressed.

Why the emphasis? In many cases, information requested or provided by correspondence is the simple step to getting paid. Providing one or two data points to the insurance company or correcting information means the payment can be processed, so in many cases correspondence represents a quick turnaround on payment if addressed promptly.

On the other hand, left unattended the billing process continues inefficiently as claims or statements are resubmitted and continually rejected, resulting in both repeated direct costs and time delays in payment. In addition, the insurance company may issue multiple requests for information, so the same information may end up being handled multiple times without resolution. The end result to the practice is that days in A/R increase and payments are not maximized.

The following are common examples of correspondence:

MISSING/INCORRECT INFORMATION REQUESTS

It can be as simple as a missing plan number or clarification of a beneficiary account number—and more likely to occur in a hospital-based practice where data collection is the responsibility of the hospital. Whatever the missing data elements, it often represents the only hurdle between the procedure performed and payment. These are often the simplest requests and the most easily addressed, resulting in prompt payment once the response is received.

ZERO PAYS

"Zero pays" are line items on the explanation of benefits (EOB) received from an insurance company. A zero payment is just that—the insurance did not pay for the service for a particular reason. However, the reason for the zero pay either represents a quick fix or presents a cause for research if the procedure was denied. The easier zero pays to work are those representing a contractual discount with the balance to be paid by the patient due to coinsurance, deductible, or co-pay obligations. The A/R representative merely has to post the adjustment shown and initiate a statement to the patient—quick and easy.

Prompt posting of zero pay procedures ensures the billing process continues smoothly, and the top performing practices specifically assign and prioritize this step. Poorly performing practices address zero pays randomly, with assignments delegated to "when you get around to it" status, often with cumbersome communications between the payment poster and person assigned to follow-up.

DENIALS

Denials may be reported in EOB line items (often as a zero pay) as part of the payment documentation, but they also come separately in the form of correspondence.

Insurance denials may include non-payment for coding inconsistencies, eligibility issues, or claims that another insurance company is responsible for payment. When denials are received, they should again be posted immediately to facilitate the work of the A/R follow-up team. Top performing organizations focus on quickly clearing denials from the work queues. Working the denial will clear it from worklists or A/R follow-up reports anyway, and if left to stack up "until I have the time," the claim will end up being handled multiple times when it could be resolved with one touch.

PATIENT CORRESPONDENCE

Patients also communicate via mail by providing insurance information in letters, or more often, written on the back of their statements. Patient correspondence also includes requests for charity or discounts and submission of death certificates on behalf of estates or family members.

KEEPING CURRENT

It is all too easy to get behind in a barrage of correspondence but the effects of not keeping up are far reaching and costly. Take a look at your practice's timely filing denials. Are they high? If so, this is the first place to look for answers.

If an insurance company has informed you that the patient is not covered by their company and that information sits for a period of time, you risk missing a tight filing deadline from the

correct insurance company. Additionally, when patients provide Workers' Compensation information on the back of their statements, that information must be processed immediately since Workers Comp in most states is notoriously strict in filing requirements.

If zero payments are not posted in a timely manner, you may also be missing out on fairly easy money from the patient, since the insured patients usually have a better track record of paying their bills than the true self pay patients. The production line work of radiology billing grinds to a halt when paper just sits in a stack. You are not likely to receive a payment not asked for.

After reviewing both top performers and lagging billing operations across the nation, there are definite commonalities in work patterns. If correspondence is worked more than one week after it's received, it is usually considered very behind. Correspondence should ideally be worked the day it is received (or the day after if it is being scanned first).

Why so adamant about the timeframe? As noted previously, timely filing is at risk but more importantly, if the A/R follow-up team has correspondence that is grossly behind and is then tasked with a worklist on top of the correspondence load, they are following up on claims very likely to be in the stack of correspondence—thus spinning their wheels and costing you money. The goal is "one touch = payment" and multiple handling or process delays are costly.

Conclusion

Working correspondence may be the most important task the A/R follow-up team completes in the course of the work day. If your organization cannot get through correspondence in a day (or two at the most), then more people need to be assigned to the effort and it needs to be elevated in priority. Working correspondence promptly and effectively is an essential ingredient for a high functioning, cost-efficient A/R follow-up effort.

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